LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

ASSISTED OUTPATIENT TREATMENT (AOT)
CANDIDATE REFERRAL FORM

Dear Referral Source:

Thank you for your interest in the Los Angeles County Department of Mental Health Assisted Outpatient Treatment (AOT) / Laura's Law Program. Before completing the referral form, please review the following:

Completing the Referral Form

If you are the person completing the application, please complete all sections of the two-page form and write legibly. If you are uncertain of any section, you may enter "Unknown", "N/A" or "0" if applicable. Do not leave any sections blank. **Incomplete referrals will not be processed.**

If a mental health provider is completing the referral form, he/she MUST BE LICENSED in order for the referral to be 'qualified' according to the statute governing AOT. If you are not licensed, please include the name of a licensed clinician (i.e. your clinical supervisor) who is familiar with the case and gives consent. Please include your Discipline (PhD, LMFT, LCSW, etc.)

Attach the following:

- **Any supporting documentation**
- **Photo**

Please Keep in Mind:

- A member of the AOT team may need to communicate with you directly (typically by phone) in order to gather additional information needed to determine referral eligibility. If the AOT investigator is unable to reach you, the referral will not be accepted. So please provide a contact number/email address where AOT staff can reach you. Please note that if you receive calls originating from County of Los Angeles cell phones may appear as 'Restricted' or 'Blocked'.

- An appropriate AOT referral would be for an individual who is refusing all forms of mental health services. If the individual is participating in some form of mental health services, the AOT referral would be deemed inappropriate. (i.e. if the individual is going to appointments but not taking medications, the referral to AOT is not appropriate. AOT cannot mandate medication.)

- AOT is unable to accept referrals for individuals whose location is unknown. You must have some idea of the potential client's location (specific corner, facility, etc.). You must also provide AOT with a picture for clients who cannot be identified by the referral party or a collateral.

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Please note that the AOT Program does not have the authority to mandate medication or involuntary long-term hospitalization/conservatorship.

Please fax completed form to (213) 402-3043 or email AOTLAOE@dmh.lacounty.gov for more information call (213) 738-2440

IF THIS IS A PSYCHIATRIC EMERGENCY PLEASE CALL ACCESS CENTER 1800-854-7771 OR DIAL 911

***INSUFFICIENT DETAILS MAY DELAY THE REFERRAL PROCESS**

DATE COMPLETED: _____

Attach recent photo here

SUPERVISOR'S NAME & DISCIPLINE: _____

INDIVIDUAL COMPLETING REFERRAL

AGENCY: _____ **NAME:** _____ **RELATION TO CANDIDATE:** _____

PHONE: _____ **EMAIL:** _____ **FAX:** _____

AOT CANDIDATE INFORMATION

SSN: _____

DMH IS#/IBHIS #: _____

LAST NAME: _____ **FIRST NAME:** _____ **GENDER:** ☐ MALE ☐ FEMALE ☐ OTHER: _____

DOB: _____ **HEIGHT:** _____ **WEIGHT:** _____ **HAIR COLOR:** _____ **EYE COLOR:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

If homeless, specify location (e.g. corner of 6th/Vermont) (Required)

PHONE NUMBER: _____ **PREFERRED LANGUAGE:** _____ ☐ **CANDIDATE SERVED IN THE U.S. MILITARY**

RACE/ETHNICITY: ☐ WHITE/NON-HISPANIC ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ UNKNOWN ☐ MULTIRACE ☐ OTHER: _____

CURRENT LIVING SITUATION:

☐ HOMELESS ☐ HOMELESS SHELTER ☐ HOSPITAL ☐ HOUSING/APT ☐ JAIL/CORRECTIONAL FACILITY ☐ SOBRIETY ☐ PSYCHIATRIC FACILITY ☐ WITH FAMILY/ADULT ☐ UNKNOWN ☐ SPECIFY AGENCY: _____

INSURANCE: CHECK ALL THAT APPLY

☐ MED-ICAL ☐ MEDICARE ☐ PRIVATE ☐ NONE ☐ OTHER _____ ☐ UNKNOWN

BENEFITS: CHECK ALL THAT APPLY AND INDICATE AMOUNTS

☐ GR RECIPIENT $ ____ ☐ V.A. $ ____ ☐ SSI $ ____ ☐ SSDI $ ____ ☐ PENDING ☐ UNKNOWN ☐ OTHER $ _____ ☐ NONE

CONCERNS OF HIGH RISK CHECK ALL THAT APPLY

☐ HISTORY/ACCESS TO WEAPONS ☐ HISTORY OF FIRE SETTING ☐ REGISTERED SEX OFFENDER

CONSERVATORSHIP ☐ YES ☐ NO IF YES, PLEASE LIST DATES, PHONE NUMBERS AND NAMES: _____

SUBSTANCE ABUSE ☐ NEVER USED ☐ CURRENTLY USING ☐ PAST USE ☐ UNKNOWN AGE FIRST USED

LIST TYPE (S) OF SUBSTANCE ABUSED & FREQUENCY: _____

INDIVIDUAL RECEIVED SUBSTANCE ABUSE TREATMENT: ☐ YES ☐ NO **TREATMENT PROGRAM** _____

PHYSICAL HEALTH ISSUES AND MEDICATION: _____

MENTAL HEALTH DIAGNOSIS: _____

LIST MENTAL HEALTH MEDICATIONS: _____

COMPLIANCE WITH MENTAL HEALTH MEDICATION

☐ TAKES MEDS REGULARLY ☐ SOMETIMES TAKES MEDS ☐ NEVER TAKES MEDS ☐ NO MEDICATIONS PRESCRIBED ☐ TAKES MEDS MOST OF THE TIME ☐ RARELY TAKES MEDS ☐ REFUSES MEDS ☐ UNKNOWN ☐ OTHER: _____

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

☐ YES ☐ NO IF YES, AGENCY: _____ **PHONE:** _____

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NAME:_____
DMH IS#/IBHIS #: _____

TYPE OF SERVICES PROVIDED: _____

HAS THE INDIVIDUAL BEEN REFERRED TO THE FOLLOWING IN THE PAST? ☐ **FSP** ☐ **SB82** ☐ **HST** ☐ **WHOLE PERSON CARE** ☐ **NONE**

	LIST DATES OF ADMISSION & DISCHARGE		REASON FOR ADMISSION/NAME OF FACILITY
NO. OF ARRESTS IN THE PAST 36 MONTHS: _____			
NO. OF PSYCH HOSPITALIZATIONS IN THE PAST 36 MONTHS: _____			

	LIST DATES	NO. OF TIMES POLICE HAVE BEEN CALLED	DESCRIBE ACT OF VIOLENCE
NUMBER OF ACTS OF SERIOUS VIOLENCE TOWARDS SELF IN THE PAST 48 MONTHS: _____			
NUMBER OF ACTS OF SERIOUS VIOLENCE TOWARDS OTHERS IN THE PAST 48 MONTHS: _____			

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Describe candidate's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including danger to self and others

Describe how the candidate is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION** (e.g. unable to care for self or provide food, clothing, or shelter)

Describe the candidate's **HISTORY OF NON-COMPLIANCE WITH TREATMENT** (has been offered the opportunity to participate in treatment and fails to engage)